A PRELIMINARY INVESTIGATION OF THE SOCIAL PSYCHOLOGY OF ATTITUDES TOWARD MEDICAL DOCTORS*

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INTRODUCTION

Favorable attitudes on the part of patients toward their doctors are widely recognized as an important element in modern psychotherapy Yet, despite observations by anthropologists that in preliterate societies popular belief in the shaman's power is an integral part of the cure, in the field of physical therapy little formal attention has been given this problem. In another study the author found that attitudes toward the medical profession held by patients released from tuberculosis hospitals were related to the tendency to complete hospitalization.† This paper presents some of the relationships found between the attitudes of these same patients toward doctors and certain other variables.

In this study attitudes are viewed not as independent "causes" but as intervening variables between individual motives and behavior. The criterion variables—attitudes toward medical doctors—are considered just such representations. Favorable attitudes toward doctors do not cause the individual to remain in the hospital until the doctor says he may leave. Favorable attitudes do, however, belong along with other attitudes to a kind of configuration, all of which together integrate the perceptions which an individual has of the hospital situation. Also, these very attitudes serve the function of selecting out certain aspects of the hospital environment for the patient to experience. And finally, attitudes toward doctors, in combination with other attitudes, probably serve to stimulate individuals to act in certain ways.

Although sociologists know little enough of the etiology of attitudes, we assume they are acquired by the self as it interacts with or experiences its social environment. Just as attitudes serve the functions of selecting, integrating, and stimulating behavior, so social interaction must offer the structural counterparts of these activities to the individual. One most effective selector in social experience is, as research studies have shown, the position which the individual holds in the social structure, or social status. In social experience, values act as integrators. The social stamping of doctors, for instance, as "good" or "bad" by other members of the child's family helps him to coordinate the various and sometimes conflicting perceptions he receives of the doctor. The stimulators are mainly found in the actions of other persons which force the person to react. When the patient enters the doctor's office and the latter looks up with a kindly smile and addresses him, the patient is compelled to action—probably to return the smile and be pleasant to the doctor. This behavior contributes to his conceptions of both the doctor and himself.

METHODS

On the basis of the rationale just described, certain hypotheses were established

*Read before the fifty-second annual meeting of The American Sociological Society, Washington, D. C., August, 1957.

†Unpublished Ph.D. dissertation: *Predicting Stay or Leave Response of Hospitalized Tuberculosis Patients*, Department of Sociology and Anthropology, The Ohio State University, 1954.

and related items were selected from a questionnaire* which had been administered to former patients at an urban county tuberculosis hospital. Criterion groups of favorable and unfavorable patients were established by devising a Doctor Attitude Scale from statements (also from the questionnaire) designed to measure attitudes toward doctors. The scale was validated and finally the significance of the differences between the responses of the criterions groups to the selected items was determined by means of the Chi Square test.

Attitudes toward doctors were hypothesized as being related to the following: *1.* Attitudes toward other specific specialists and toward experts in general. *2.* Attitudes toward selected dimensions of the role of doctors in our society. *3.* The social statuses occupied by any given individual in this society. *4.* The evaluation of medical doctors made by the individual's family and the actions of doctors as perceived by the patient.

TABLE 1

Attitudes toward certain other experts, held by respondents classed as favorable and unfavorable toward medical doctors

Items	Attitudes Toward Medical			
	Favorable		Unfavorable	
	No.	Percent	No.	Percent
1. Greater self-knowledge than psychiatrist:				
Agree	11	28.2	25	41.7
Disagree	28	71.8	35	58.3
Total	39	100.0	60	100.0
2. More confidence in mothers than in teachers:				
Agree	17	48.6	39	66.1
Disagree	18	51.4	20	33.9
Total	35	100.0	59	100.0
3. Nurses act as though sick are inferior:				
Agree	1	2.7	22	36.7
Disagree	36	97.3	38	63.3
Total	37	100.0	60	100.0
4. People being pushed around by experts:				
Agree	16	40.0	43	72.9
Disagree	24	60.0	16	27.1
Total	40	100.0	59	100.0

The following six statements were incorporated in a crude scale, each item being arbitrarily assigned two weights. To make a score optimum to favorable toward doctors, a respondent would have to disagree with these items: *1.* Doctors tend to act superior to their patients. *2.* Doctors today seem to be more interested in money than in their patients. *3.* It is difficult to find a doctor you can really trust. *4.* Too many doctors treat their patients as if they were not capable of understanding anything. And the subject would have to agree with these: *5.* Doctors ought to be respected by everyone. *6.* Doctors cannot be expected

*The questionnaire was used in gathering data for the unpublished Ph.D. dissertation: *Predicting Stay or Leave Response of Hospitalized Tuberculosis Patients.*

to tell their patients much since they have so much technical knowledge that only another doctor could understand.

Patients who failed to respond to more than three items were discarded from the sample. On the average, four of these six items were responded to favorably. Patients with scores falling in the classes below the mean were assigned to the "Unfavorable" category, and those in the classes above, to the "Favorable," the mean class having been excluded from the analysis.

Talcott Parsons (1951) has characterized the ideal patient-doctor relationship as one in which the physician tries to help and the patient cooperates. To determine the validity of the scale, that is, whether the six items really discriminate between those who hold favorable and unfavorable attitudes, the two groups were examined in terms of their cooperation with doctors at the tuberculosis hospital. One measure of cooperation was whether the patient left the hospital with or against medical advice. Thirty-five of the forty-one Favorable patients left with medical advice; on the other hand, forty of the sixty-two who were Unfavorable left against the advice of their doctors. Differences between these distributions are significant at the one percent level of confidence.

TABLE 2

Attitudes toward one aspect of the doctor's role—(impersonal authority), held by respondents classed as favorable or unfavorable toward medical doctors

Items	Attidues Toward Medical			
	Favorable		Unfavorable	
	No.	Percent	No.	Percent
1. Beneficiaries of rules are those who enjoy enforcing them:				
Agree	7	17.9	24	40.7
Disagree	32	82.1	35	59.3
Total	39	100.0	59	100.0
2. Most red tape is unnecessary:				
Agree	15	42.9	44	74.6
Disagree	20	57.1	15	25.4
Total	35	100.0	59	100.0

RESULTS AND DISCUSSION

Three items in the questionnaire seemed to be indicators of opinions about specific experts; one item, about experts in general. They are: *1.* I know more about myself than anybody else can ever know about me, including a psychologist or psychiatrist. *2.* Young, unmarried women with college degrees teaching in our public schools know less about handling children than the mothers who have learned from experience with their own children. *3.* Nurses act like sick people are inferior to other people. *4.* An awful lot of people are being pushed around by so-called experts.

Distributions on these items appear in table 1. Differences between the two groups are statistically significant for only the last two items. In this sample, differences between patients favorable and unfavorable toward doctors were not observed on the questions involving acknowledgment of skills of specific experts, there being general agreement about the superior knowledge of a psychiatrist or psychologist compared with laymen, and the questionable abilities of college trained teachers compared with mothers. On the other hand, unfavorableness toward doctors appears to be related to opinions about the manner in which

certain experts act toward other persons. On the face of it, agreement with the statements about the condescending behavior of nurses and the manipulating acts of experts involves threats to the security of the individual, whether to that of ego or someone else. There appears to be some relationship between answers to the two questions since all fifteen respondents who agreed with both questions were in the Unfavorable group. Of the twenty-four Favorable patients who disagreed with the statement about experts, twenty also disagreed with the nurse statement. Before leaving the discussion of these items, it should be mentioned for the benefit of readers who recognize the question on so-called experts as deriving from the F-test (Adorno et al., 1950) that for this study the item was accepted at face value. The interpretation, therefore, does not hinge upon "depth psychology" theories.

TABLE 3

Some differences in selected social statuses of respondents classed as favorable or unfavorable toward medical doctors

Items		Attitudes Toward Medical			
		Favorable		Unfavorable	
		No.	Percent	No.	Percent
1. Race:	White	26	63.4	51	82.3
	Other	15	36.6	11	17.7
	Total	41	100.0	62	100.0
2. Occupational prestige:	73–93	5	13.2	5	8.8
	63–72	9	23.7	18	31.6
	53–62	10	26.3	28	49.1
	33–52	14	36.8	6	10.5
	Total	38	100.0	57	100.0
3. Sex:	Male	24	58.5	29	46.8
	Female	17	41.5	33	53.2
	Total	41	100.0	62	100.0
4. Age:	50 years and over	9	22.0	8	12.9
	35–49	10	24.4	9	14.5
	25–34	17	41.4	28	45.2
	under 24	5	12.2	17	27.4
	Total	41	100.0	62	100.0
5. Education:	Beyond high school	5	12.2	9	14.5
	High school	20	48.8	34	54.8
	Eight or less grades	16	39.0	19	30.7
	Total	41	100.0	62	100.0

Two items in the questionnaire were classified as being indicators of one important dimension of the doctor's role in our society—impersonal authority.

1. The people who benefit most from rules and regulations are the ones who get satisfaction from laying them down to others.

2. On the whole, most of the red tape you come across today is really not necessary.

The manner in which the two groups responded to these statements may be observed in table 2. The probability of differences as large as are found in the responses of the two groups to the first item is less than two out of one hundred; for the distribution on the second item, less than one out of one hundred.

The common element in the two items—"red tape" in the one and "rules and

regulations" in the other—provides the clue to an understanding of impersonal authority. It is clearly demonstrated in the "red tape" situation where someone either explicitly or implicitly imposes "rules and regulations" on some important area of an individual's life (Parsons, 1951, p. 434). In the last analysis, decisions are made not on the basis of the individual's immediate relationship to this person, but in terms of general rules or laws covering such cases as his (Merton, 1949, p. 158). Facing this type of authority, the individual may be forced into recognizing his own inability to alter his position in the power relationship. Consequently, the confrontation of impersonal authority leaves certain individuals with a sense of powerlessness (Gouldner, 1952, p. 410).

Distributions of the two groups by selected social statuses are shown in table 3. There is a significantly greater (at the five percent level) number of minority group members in the Favorable group. There is also a significantly greater proportion of very low prestige occupations (National Opinion Research Center, 1947, pp. 411–426) and a lower proportion of next-to-the-highest prestige occupations in the Favorable group. Three status factors did not appear to be related to attitudes toward doctors—sex, age and education.

TABLE 4

Effects of evaluation and actions of medical practitioners on respondents classed as favorable or unfavorable toward medical doctors

Items	Attitudes Toward Medical			
	Favorable		Unfavorable	
	No.	Percent	No.	Percent
1. Family practice of calling in or going to doctors:				
Yearly check and went immediately	24	64.9	36	65.5
Delayed and never went	13	35.1	19	34.5
Total	37	100.0	55	100.0
2. Change in attitude toward doctors since hospitalization:				
Change	11	27.5	30	49.2
No change	29	72.5	31	50.8
Total	40	100.0	61	100.0

The associations between both lower occupational status and minority group status and the criterion are discussed jointly because of the well-documented relationships between the two status factors. One explanation for the findings may lie in the fact that such individuals, who as a result of their status are in so many ways vulnerable to exploitation, have recourse to few alternatives other than faith in authority. Applicable are the studies which show that Negro and lower class elements are attracted to such religious movements as Father Divine, the Holy Rollers, etc. (Fauset, 1944; Powdermaker, 1939). Higher status individuals, while they do not have all the technical information bearing on their particular case, can exercise a greater degree of rational behavior in the total situation than can lower class persons. Furthermore, the data are suggestive that individuals with higher socio-economic status, being accustomed to more degrees of freedom, express more criticism of those who are in a position to restrict it.

One question was believed to determine indirectly the evaluation of medical doctors made by the patient's family of orientation. Patients were asked, "How did your family (in which you grew up) feel about calling in or going to doctors?" Differences between the answers of the two groups are not greater than one might expect from chance (table 4).

Since for many patients their most recent contact with doctors was that at the hospital, the question following the check list of items about doctors was believed to be pertinent for determining the effects while the actions of doctors have on patients. "Do you think your opinions about doctors are different since you have been in the TB hospital?" Whereas almost two-thirds of the Favorable group answered that they had not experienced any change of attitudes toward doctors as a result of hospitalization (table 4), about half of the Unfavorable group reported that their attitudes had been changed. Differences are significant at the five percent level.

It is to be noted then, that whereas the evaluation of doctors made by the individual's family does not appear related to attitudes toward doctors, the person's reactions to doctors at the hospital do appear to enter in.

CONCLUSIONS

This study offers a contingency technique to study what medical people might call the epidemiology of favorable-unfavorable attitudes toward physicians, being limited to a special category of subjects. The limitations of this technique in establishing causal relationships are recognized as well as the weakness deriving from the fact that the study was not designed with the above analysis in mind. For these reasons the findings are presented as suggestive of the need for further investigation.

With regard to the hypotheses set forth in the early part of the paper, the results of the item analysis in the last section indicate that more specificity in the hypotheses is merited in order to test them conclusively. On the basis of the evidence presented in this paper, the hypotheses might be restated as follows:

1. Unfavorable attitudes toward doctors are related to unfavorable attitudes toward the manipulative and condescending aspects of the behavior of other specialists with regard to the respondents themselves and others.
2. Unfavorable attitudes toward medical doctors are related to unfavorable attitudes toward impersonal authority.
3. Unfavorable attitudes are related to higher than average occupational status and to majority group status (racially).
4. Unfavorable attitudes are related to the way in which medical doctors act toward patients in their professional relationships with them.

If further data should permit the researcher to reject the null hypotheses, a generalization based on possible inter-relationships between the four hypotheses might be made. We might speculate that unfavorable attitudes toward medical doctors are part of an attitude-behavior pattern which derives from the status-role configuration which centers around specialists of various kinds and the recipients of their services. That is, persons in the more prestigeful statuses in our society (such as White and occupationally higher) are expected to resent impersonal authority and to feel distrustful of the power of persons institutionally provided with it, such as specialists of various kinds whose training and skills may or may not be acknowledged. Such status-connected attitudes are reinforced to a considerable degree by the experiences which the status-occupants have with the specialists.

The actual results of this study and the discussion of the usefulness of testing more specific hypotheses appear to point up questions in three major areas, as follows:

1. What is the etiological significance of attitudes toward physicians? In this connection, the interaction aspects of the patient-doctor relationship require considerably more investigation. One notable study of the observation of patient-doctor interaction on a ward is by Caudill (1952). We have indicated that some doctors may act or fail to act in such a way as to deserve the unfavorable opinion of their patients; the techniques of the Caudill study might be oriented toward the

problem of what it is that actually happens in the hospital to change the patient's good opinion of doctors.

2. Closely related and more important methodologically, what assurance do we have that the criterion variables selected for these studies, such as Favorable-Unfavorable, one side of which represents certain approved values having a high rating in our cultural context, are not blinding us to our own findings? Even our hypotheses may reflect conscious or unconscious favoratism, as specialists ourselves, toward the "Favorable" respondents.

3. What general trends in social structure are indicated by hostility toward and suspicion of experts in a society in which there is a growing dependency upon such persons? Research in this area could lead to important findings regarding value orientations in American society (Williams, 1951). Perhaps acceptance of technologically and professionally trained elites necessarily conflicts with democratic ideologies, which are more rigorously held by certain segments of our population than others.

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